Client Name: ____

Date of Birth: ______________________ **Case #**______________

I authorize Woodland Centers: to ______ Exchange with OR ______ Disclose to OR ______ Obtain from

Name of Organization or Individual: ____

Mailing Address: ____

City/State/Zip: ______________________ **Telephone #:** ______________________ **FAX #:** ______________

Reason for Release:

- ☐ Coordination of Care
- ☐ Per Client Request
- ☐ Per request of above-identified family member
- ☐ Financial/Billing
- ☐ Legal
- ☐ Other ______________________

Records from the Following Dates: ☐ All (Including Past, Present, Future) ☐ Specific date(s) ____________ to ____________

Information to be Released (please mark appropriate boxes):

- ☐ Any/All Records (Includes ALL records listed below, excluding substance use program records unless specifically indicated below)
- ☐ Summary of Services (Includes Discharge Summary, History/Physical, Consultations, and Test Results)
- ☐ Mental Health Evaluations (Including Psychological Testing)
- ☐ Treatment Plan/Functional Assessment
- ☐ Progress Notes/Office Visits
- ☐ Medications
- ☐ Lab/Radiology Reports
- ☐ Legal/ Court/ PO
- ☐ School Records
- ☐ Social Services
- ☐ Verbal Only (No Records)
- ☐ Other (Specify Content): ____

SPECIFIC AUTHORIZATION FOR RECORDS PROTECTED UNDER 42 CFR PART 2: (includes records pertaining to SUD treatment and/or Detox Programs):

- ☐ Substance Use Disorder/Chemical Dependency Records

I UNDERSTAND:

- Records may include information regarding treatment for alcohol or drug abuse.
- I authorize the release to include records occurring prior to and past the date of signature, until the authorization expires or is revoked, unless I have specified a date range (see above).
- I have the right to revoke this authorization at any time by giving written notice to Health Information Management Services. Revocation will not apply to records that have already been released.
- I need not sign this authorization to receive services unless the services are court-ordered or are being created solely for a third party.
- Woodland Centers cannot prevent the redisclosure of records released as a result of this request, and after the information is released from Woodland Centers, the records may not be subject to privacy rule protections.
- This authorization will permit two-way telephone communication and exchange of information by electronic transmission.
- I am entitled to a copy of this authorization once I have signed it. I may review/request copies of information disclosed.
- A photocopy or facsimile of this authorization is as effective as the original.

This authorization shall remain in effect until the following date: ______________ **(If no date is indicated, the authorization expires one year from the date signed.)**

______________________	__________	______________________	__________
Client Signature	**Date**	**Witness Signature**	**Date**

______________________	______________________	__________
Parent/Guardian Signature	**Relationship to Client**	**Date**

Information should be sent to Woodland Centers, Attention: ______________________ **at:**

- ☐ Big Stone Center: 28 2nd St NW, PO Box 145 Ortonville, MN 56278 :: 320-839-8322 Fax: 855-867-8780
- ☐ Chippewa Center: 1234 E Hwy 7, PO Box 187 Montevideo, MN 56265 :: 320-269-6581 Fax: 320-269-7045
- ☐ Kandiyohi Center: 1125 SE 6th St, PO Box 787 Willmar, MN 56201 :: 320-235-4613 Fax: 855-625-7406
- ☐ Lac qui Parle Center: 669 6th St, PO Box 493 Dawson, MN 56232 :: 320-769-4864 Fax: 855-275-1310
- ☐ Meeker Center: 114 N Holcombe Ave, Suite 230, PO Box 55 Litchfield, MN 55355 :: 320-693-7221 Fax: 855-825-0812
- ☐ Renville Center: 902 W Lincoln Ave, PO Box 84 Olivia, MN 56277 :: 320-523-5526 Fax: 855-675-6425
- ☐ Swift Center: 1213 Pacific Ave, Benson, MN 56215 :: 320-843-2061 Fax: 855-482-7868
- ☐ Tri Star ACT: 215 Milkyway St S, PO Box 577 Cosmos, MN 56228 :: 320-877-7220 Fax: 320-877-7479

For office use only: Entered by: __________
Date: __________